Missouri Department of Social Services
Family Support Division
BCCT MO HealthNet Application

SMHW PROVIDER
TELEPHONE NUMBER
DIAGNOSIS DATE

FOR OFFICE USE ONLY		
DATE APPLIED		
DCN		
☐ SERVICE REP	☐ SUPERVISOR	☐ LOAD

COMPLETE IN INK

A. MAILING ADDRESS

NAME (FIRST, MIDDLE, LAST)	MAIDEN NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	RACE/ETHNIC
ADDRESS (HOUSE NO., STREET, RURAL ROUTE, PO BOX NO) CITY, STATE, ZIP CODE, COUNTY				

HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	MESSAGE TELEPHONE NUMBER

B. INSTRUCTIONS: Please answer each question completely.

	YES	NO
1. Born in Missouri?	☐	☐
2. Are you a U.S. citizen? If **"NO"**, list immigration status and registration number, date of entry:	☐	☐
3. Do you currently have healthcare insurance?	☐	☐

NAME OF COMPANY AND POLICY NUMBER	TYPE OF COVERAGE
	☐ DOCTOR ☐ HOSPITAL (**If limited coverage, explain**)

	YES	NO
4. Do you have children under the age of 19 residing in your home?	☐	☐
5. Are you pregnant?	☐	☐
6. Are you blind?	☐	☐
7. Are you disabled?	☐	☐

C. PLEASE READ CAREFULLY AND SIGN BELOW:

- I agree to provide Social Security Numbers of all persons applying for MO HealthNet as required by law. The social security number is used to determine eligibility and verify information.
- I agree that my statements and information provided may be verified.
- I will report any changes in circumstances within TEN DAYS of when they happen.
- I know that it is against the law to obtain benefits to which I am not entitled. Any false claim, statement or concealment of any material fact whatsoever, in whole or in part, may subject me to criminal and/or civil prosecution.
- I agree that medical information about me can be released if needed to administer this program.
- I understand MO HealthNet benefits based on a person being blind, disabled, age 65 or over, pregnant women, child or parent, is not determined by completing this application. If I want eligibility for healthcare benefits explored on the basis on one of these, I must complete a different application for these benefits.
- Provided I am found to be eligible for MO HealthNet, I know the state of Missouri will pay for covered services on my behalf and agree the state may collect payments from any third party (i.e., insurance, estate, etc.) for services paid by the state.
- I understand that if I disagree with the decision concerning my eligibility, I may request a fair hearing within 90 days of the date of the decision.

I agree that the signature below certifies under penalty of perjury that all declarations made in this eligibility statement are true, accurate, and complete, to the best of my knowledge.

SIGNATURE	DATE

CALL FAMILY SUPPORT DIVISION'S MO HEALTHNET SERVICE CENTER, TOLL-FREE, 1-888-275-5908, IF YOU HAVE ANY QUESTIONS.